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AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/01/16 through 11/03/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #16) and four closed record reviews (Residents #17 through #20).	F 000		
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(b)(5) - (10), 483.10(b)(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		11/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined for two of 20 residents in the survey sample (Residents #18 and #20) that facility staff failed to assure the residents were informed in writing that services were being discontinued and that they had a right to appeal. The findings included: 1. Resident #18 did not receive a written notice of the discontinued services (therapies) and his right to appeal the stoppage. Resident #18 was 65 years old and was admitted to the facility on 9/24/16 following a hospitalization. The resident was admitted for	F 156	F 156 1. No correction could be made for resident # 18 and # 20 as they were discharged from facility prior to survey 2. All patients receiving skilled services are at risk for this issue 3. The administrator or designee will educate Social Worker and Business Office manager the procedure of sending notices to resident or responsible party 4. The administrator or designee will audit all residents discharged from skilled service to insure notification was sent and received by resident or responsible party. Audits will be reported to QA committee. 5. Completion date 11-25-16	

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Physical and Occupational Therapy (PT and OT). The resident's diagnoses included chronic atrial tribulation, chronic obstructive pulmonary disease (emphysema) anxiety and chronic respiratory failure.

Review of the 14 day Minimum Data Set (MDS) with an assessment review date of 10/7/16 evidenced the the resident was cognitively intact with a brief interview for mental status of 15 out of 15. The resident required limited to extensive assistance of one person with his activities of daily living.

On 11/3/16 at approximately 11 am the facility administrator was requested to provide "Advanced Beneficiary Notices" for three closed records. A short time later one ABN was received but not Residents #18 and 20. Approximately 1 pm the ABNs were again requested from the administrator. The Administrator stated he was unable to find the ABN letters. The Social Worker was responsible for sending out the letters but she had recently resigned. He stated, "We have looked but can not find".

The acting Social Worker was interviewed at approximately 2 pm and stated she does admissions but until a new Social Worker was hired she was doing discharges. She also stated we have searched but can not find the letters.

Review of the clinical record evidenced Resident #18 received PT and OT. The PT notes evidenced the resident reached his goals on 10/20/16 and OT documentation evidenced goals were reached on 10/19/16. Resident #18 was discharged home on 10/20/16.

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Review of the facility DISCHARGE/TRANSFER LETTER POLICY, last reviewed 1/2014 included information that directed the discharge letter would include: the reason and date of discharge, and a statement that the resident has a right to appeal the decision to the State.

During an 11/3/16 3:30 pm meeting with the administrative staff the team requested any additional information the facility wanted to provide. No further information was provided.

2. Facility staff failed to inform Resident #20 in writing of services ending and the right to appeal the end of services.

Resident #20 was admitted to the facility on 8/9/16 and re-admitted on 8/16/16 and discharged on 8/25/16. Diagnoses for Resident #20 included but are not limited to PVD (Peripheral Vascular Disease impacts blood flow), end stage renal disease (loss of renal function, need for dialysis), diabetes (increased sugar levels), dementia, and displaced fracture of right femur. Resident #20's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/16 coded Resident #20 with a Brief Interview Minimum Set (BIMS) score of 8 indicating cognitive impairment. Also, Resident #20 was coded as dependent on staff for Activities of Daily Living (ADLs-bed mobility, transfer, dressing and hygiene).

On 11/3/16 Resident #20's clinical record was reviewed in a closed record review. Discharge Summaries for speech, occupational, and physical therapy were reviewed. Resident #20 received Speech Therapy from 8/17/16 through

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8/24/16, Occupational Therapy from 8/23/16 through 8/24/16 and Physical Therapy from 8/17/16 through 8/24/16. On all three Therapy Discharge summaries Resident #20 had a payor source of Medicare Part A. Documentation was not found to provide evidence that Resident #20 was informed of services ending. No documentation was found that Resident #20 was informed of his right to appeal the end of services.

According to a clinical nursing note dated 8/25/16, it was documented that Resident #20 was "Discharged..transported to vascular doctor appointment then home." Another note from Social Services dated 6/25/16 documented "Resident [#20] being discharged today with hospice".

On 11/3/16 at approximately 1:00 p.m. the Administrator stated, "We have a folder of all the cut letters [end of service letters] but I could not find one for this resident [#20]." On 11/3/16 at approximately 1:30 p.m. the Business Office staff stated, "We do not have the cut letter for this resident [#20]." Also, the Administrator stated on 11/3/16 at approximately 2:00 p.m. that the Social Worker for the facility was no longer working and the "Cut Letters [End of service letters/right to appeal]" could not be located.

According to the Discharge/Transfer Letter Policy last revised on January 2014 documented, "Social Services will document all discharges..any notices given to the resident or guardian." and "Discharge notices must include a statement that the resident has the right to appeal."

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F 156	Continued From page 6 The facility administration was informed of the findings during a briefing on 11/3/16 at approximately 3:25 p.m.. The facility did not present any further information about the findings.	F 156		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility documentation review, the facility staff failed to provide the necessary care to ensure residents maintained the highest practicable level of well-being for three of 20 residents (Resident #9, #10 and #17) in the survey sample. 1. The facility staff failed to use non-pharmacological interventions prior to administering pain medication for Resident #9. 2. The facility staff failed to implement non-pharmacological interventions prior to the administration of pain for Resident #10. 3. The facility staff failed to follow physician orders for neurological checks every 4 hours for Resident #17.	F 309	F-309 1 No correction to be made for residents # 9, 10, 17 2 Any resident receiving PRN pain medicine or orders for neurochecks are at risk 3 Inservice by DSD or designee for licensed nursing staff to offer non pharmacological interventions for pain prior to administering medication. Performing nuerochecks,documenting and following physician orders 4 D.O.N. or designee will audit residents receiving PRN pain medications to ensure non pharmacological interventions were offered or tried , daily x 2 months then random weekly x 3 months . All audit results will be reported to QA	11/25/16

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F 309	Continued From page 7 The findings included: 1. Resident #9 was admitted to the facility on 04/06/12. Diagnosis included but not limited to major depression disorder, stroke, muscle weakness, Osteoarthritis (OA) spondylosis without myelopathy or radiculopathy (cervical region) and repeated falls. Resident #9's Annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/11/16, coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 8 out of a possible score of 15, which indicated the resident was moderately impaired in decision making skills. This resident was not assessed with any behavioral issues. This resident's MDS was coded for pain occasionally. Resident #9 received an order on 05/16/2016 for *Acetaminophen Tablet 325 mg (milligrams) - Give 2 tablets by mouth every 4 hours as needed (prn) for elevated temperature/pain. *Acetaminophen is a widely used nonprescription analgesic and antipyretic medication for mild-to-moderate pain and fever. (National Institutes of Health) (National Library of Medicine) nih.gov Review of the Medication Administration Record (MAR) and nurses notes indicates that Resident #9 received Acetaminophen 325 mg 2 tablets (650 mg) on the following days without any non-pharmacological interventions prior to the administration of prn pain medication: November 2016 on 1; October 2016 on 8, 9, 13, 14, 17, 22, 27 and 31 and September 2016 on 11, 16, 20, 29	F 309	committee 5 Completion date 11-25-16	

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and 30.

On 11/2/16 at 12:55 p.m., an interview was conducted with the LPN #3 (Unit Manager-West), this surveyor asked the Unit Manager what is the process before administering prn pain medication, she stated, "Ask the resident on a pain scale of 1/10 with 1 at the lowest and 10 at the highest. I will then go and check the order, pull the medication, sign off the medication in the narcotic book and also check to see the last time the resident had pain medication. I would then administer the medication, then go back and check for effectiveness 30 minutes to 1 hour later, sign the chart and the effectiveness of the medication. Last, I will write in the nurses note the location and score of the residents pain".

On 11/3/2016 at 2:15 p.m., during an interview with LPN #4, this surveyor asked what is the process for the administration of prn medication, she replied, "Assess resident, ask pain scale 1/10 with 1 at the lowest and 10 the worst, check the MAR for order, give the medication according to the pain level, sometimes a resident may have several pain medication according to their pain scale then I'll go back and reassess pain after." This surveyor asked LPN #4 about non-pharmacological interventions prior to administration of prn pain medications, she replied, "Oh yes, I also do that". LPN #4 was asked when was the last time she offered non-pharmacological interventions prior to giving prn pain medication and documented those interventions in the nurse's notes, she replied, "This past weekend, October 29th and 30th." LPN # 4 stated she worked on the back hall (West End) unit.

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On 11/3/16 at 3:45 p.m., this surveyor requested the MAR for October 2016 and nurse's notes for the West End Unit for October 29th and 30th from RN #1 for any residents who received non-pharmacological inventions prior to receiving prn pain medication.

On 11/3/16 at 3:55 p.m., RN #1 approached this surveyor and stated, "I was unable to locate any nurse's notes that indicated non-pharmacological interventions were used prior to administering prn pain medication".

The facility Administrator, DON, corporate nurse and RN #1 was informed of findings during a briefing on 11/3/16 at 4:00 pm. The facility did not present any further information about these findings.

The facility policy: Pain assessment effective date 11/1/2014. Procedure: The nurse will document the intervention done and the site and severity of pain or discomfort. The facility policies did not include non-pharmacological interventions prior the administration of prn pain medication.

2. Resident #10 was admitted to the nursing facility on 6/6/16 with diagnoses that included polyneuropathy, muscle weakness, chronic back pain and diabetes.

Resident #10's most recent Minimum Data Set (MDS) assessment dated 10/5/16 was a significant change in status and coded the resident with a score of 15 out of a possible score of 15, which indicated the resident had no problems with the cognitive skills needed for daily decision making. The resident was assessed as having occasional pain and received as needed

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(PRN) pain medication.

The resident's care plan dated 6/16/16 identified actual pain related to healing right heel fracture and additional pain related to arthroplasty, peripheral artery disease (PAD) and neuropathy. The goal the staff set for the resident was that they maintain the resident's comfort to the highest degree possible. Some of the approaches the staff would use to accomplish this goal included administer pain medication as ordered, (diathermy) rehabilitation services and to attempt non-pharmacological interventions.

Resident #10 had a current physician orders dated 7/26/16 for Acetaminophen Extra strength, 500 milligrams (mg) by mouth every four hours PRN.

Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body (https://medlineplus.gov/druginfo/meds/a681004.html).

Review of the Medication Administration Records (MAR), Resident #10 was administered Acetaminophen Extra strength 500 mg 11 times in the month of July 2016, 6 times in August

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2016, 7 times in September 2016, 4 times in the month of October 2016 and 2 times in November 2016.

An interview was conducted with the West Unit Unit Manager Licensed Practical Nurse (LPN) #3 on 11/2/16 at 3:45 p.m. She stated she offers other comfort measures prior to administering pain medication and documented interventions in the nurse's notes. The nurse's notes did not reveal any non-pharmacological measures prior to administration of pain medication. The MAR indicated the resident was asked to rate her pain on a scale of 1-10, after which the medication was administered and afterwards documented its effectiveness.

On 11/3/16 at 1:45 p.m., an interview was conducted with LPN #2. She stated she played music, rubbed the resident's back and offered repositioning which was documented in the nurse's notes. There were no nurse's notes that indicated the aforementioned non-pharmacological measures were tried prior to administering pain medication.

On 11/3/16 at 2:00 p.m., an interview was conducted with LPN #3. The LPN said she asked the resident her level of pain based on a pain rating scale of 1-10, administered the pain medication and went back to see if it was effective. She stated, "That's all we have to do. If they were on an psychoactive medication we would document what we do before we give that, but never before we give pain medications."

An interview was conducted with Resident #10 on 11/2/16 at 11:30 a.m. She stated the Rehabilitation department administers diathermia

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treatments to her foot which helped her pain, but staff just administers pain medication when she asks for it. She said she suffered from leg, foot and chronic back pain.

The facility Administrator, DON (Director of Nursing), corporate nurse and RN # 1 were informed of findings during a briefing on 11/3/16 at 4:00 pm. The facility did not present any further information about these findings.

3. Resident #17 was initially admitted to the facility on 7/14/04 with a readmission date of 5/12/15. Diagnoses for Resident #17 included but are not limited to Heart Failure (a condition where the heart can't pump enough blood to meet the body's need), Atherosclerosis (a condition where the arteries that supply blood to heart muscle become hardened and narrowed), history of Venous Thrombosis and Embolism (blood clot) and Stage II Sacral Pressure Ulcer*.

Resident #17's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 2/2/16 coded Resident #17 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no impairment in cognition. In addition, the Minimum Data Set coded Resident #17 requiring extensive assistance with two staff person assistance for transfers. Resident #17 was coded as requiring extensive assistance with one staff person assistance in dressing and as occasionally incontinent of both urine and bowel.

A nursing progress note dated 5/4/15 at 10:40 (10:40 a.m.) documented the following: "Report to this writer resident not eating complaining of head and neck pain, and having unusual

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AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

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movements noted to the left arm. No bruising noted, no abrasions noted, pt (patient) can open and close eyes on demand, smile and stick out tongue and wiggle it from side to side, unable to follow through with squeezing my finger. MD (medical doctor) called left message with ... and she will call us back after MD reviewed note. Awaiting any new orders."

A nursing progress note dated 5/4/15 at 14:31 (2:31 p.m.) documented the following: "(Doctor's) office ordered neuro check (neurological check/assessment for level of consciousness) q (every) 4 hours x (for) twenty four hours. Pupils non-reactive and surrounded by cataracts. Dr. ... office made aware of non-reactive pupils. Will continue to monitor. ..."

Registered Nurse #1 stated on 11/3/16 at approximately 2:30 p.m. that the order was put into the system 5/4/15 at 12:41 p.m.

Review of Resident #17's clinical records documented the following neuro checks that were not done every 4 hours as ordered by Resident #17's Physician:
5/4/15 12:53 (12:53 p.m.)
5/4/15 18:17 (6:17 p.m.)
5/4/15 20:06 (8:06 p.m.)
5/5/15 12:25 (12:25 a.m.)
5/5/15 05:48 (5:48 a.m.)

Registered Nurse #1 stated on 11/3/16 that he found no other documentation related to Physician ordered neuro checks to be done every 4 hours for 24 hours.

The facility administration was informed of the

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F 309	Continued From page 14 findings during a briefing on 11/3/16 at approximately 4:45 p.m. The facility did not present any further information about the findings. *Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).	F 309		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.25(a)(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint	F 312	F 312 1. Resident # 3 nails were immediately	11/25/16

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F 312	Continued From page 15 investigation, the facility staff failed to maintain trimmed fingernails for 1 Resident (Resident #3) of 20 residents in the survey sample. The findings included: Resident # 3 was initially admitted to the facility on 12/10/15 with a readmission on 5/2/16. Diagnoses for Resident #3 included but are not limited to Debility and Metabolic Encephalopathy (describes temporary or permanent damage to the brain that happens when the body's metabolic processes are seriously impaired. Most cases occur when the liver cannot act normally to remove toxins from the bloodstream). Resident #3's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 5/11/16 coded Resident #3 with a BIMS (Brief Interview for Mental Status) Score of 12 of 15 indicating moderate impaired cognition In addition, the Significant Change Minimum Data Set coded Resident #3 requiring extensive assistance with two staff person assistance for transfers. Resident #3 was coded as requiring total dependence with one person assistance for dressing and personal hygiene. During an observation of Resident #3 on 11/2/16 at approximately 2:00 p.m., Resident #3 was observed sitting in the hall close to the nursing station. Resident #3 had a sheet covering his body and his head. During a conversation with Resident #3, the surveyor pulled down the sheet to see the resident's face. The resident was requesting to go back to bed as he was cold. During the conversation, Resident #3's fingernails were observed to be extremely long. The Director of Nursing was informed of Resident	F 312	cleaned & trimmed , 100 % audit of all current residents conducted to ensure nails were clean and trimmed 2 All residents are at risk for this issue 3 Inservice by DSD for nursing dep□t staff on cleaning and trimming nails 4 Audit by unit managers or designee Mon □Fri to ensure nails are clean and trimmed . Audit results to be shared with QA committee 5 Completion date 11-25-16	

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F 312	Continued From page 16 #3's long fingernails on 11/2/16 at approximately 3:00 p.m. The Director of Nursing was asked on 11/3/16 at approximately 2:30 p.m. if Resident #3's fingernails should have been allowed to grow that long without providing grooming needs to the resident. The Director of Nursing stated, "No." The facility policy titled, "Nail Care" with an effective date of January 2011 and a last reviewed date of January 2014, documented the following: "Nursing staff will administer nail care in order to provide cleanliness and prevent infection." The facility administration was informed of the findings during a briefing on 11/3/16 at approximately 4:30. The facility did not present any further information about the findings.	F 312		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(d) Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint	F 315	F- 315 1. Foley catheter was immediately	11/25/16

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F 315	Continued From page 17 investigation, the facility staff failed to accurately secure foley catheters of 2 Residents (Resident #1 and Resident #3) of 20 residents in the survey sample. The findings included: 1. Resident #1 was initially admitted to the facility on 7/14/04 with a readmission date of 5/12/15. Diagnoses for Resident #1 included but are not limited to Heart Failure (a condition where the heart can't pump enough blood to meet the body's need), Atherosclerosis (a condition where the arteries that supply blood to heart muscle become hardened and narrowed), history of Venous Thrombosis and Embolism (blood clot) and Stage II Sacral Pressure Ulcer*. Resident #1's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 2/2/16 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no impairment in cognition. In addition, the Minimum Data Set coded Resident #1 requiring extensive assistance with two staff person assistance for transfers. Resident #1 was coded as requiring extensive assistance with one staff person assistance in dressing and as occasionally incontinent of both urine and bowel. On 11/2/16 at approximately 11:30 a.m., during an observation of Resident #1's sacral wound care, Resident #1's foley catheter anchor was observed not adhered to her thigh. The catheter anchor was observed stuck to the foley tubing. The Licensed Practical Nurse nor the Certified Nursing Assistant commented that the foley catheter was not anchored during the process of	F 315	secured for resident # 1 and # 3 2. All residents with foley catheters are at risk 3. DSD will inservice nursing staff on securing foley catheter tubing 4. Unit manager or designee will audit daily x 1 month, then random weekly ongoing and shared with QA committee 5. Completion date 11-25-16	

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cleaning Resident #1 after a bowel movement and during wound care.

On 11/2/16 at approximately 4:00 p.m., LPN (Licensed Practical Nurse) #5 was asked to go into Resident #1's room to observe her foley catheter. The LPN pulled back the cover to show how Resident #1's catheter was anchored. Resident #1's catheter was observed to be stuck to the foley catheter tubing and not adhered to the thigh. The anchor was observed in the same location as it was observed earlier in the day.

The LPN stated, "I will get another anchor to secure her catheter."

Resident #1's 10/4/16 Physician Order documented the following: "Anchor catheter tubing and check placement every shift.

Resident #1's Treatment Administration Record (TAR) November 2016 documented every shift that placement of foley catheter was checked.

The facility policy titled, "Catheter Care Urinary Male-Female" with an effective date of 2/2011 documented the following:
"The purpose of this is to prevent infection of the resident's urinary tract along with daily visualization of the catheter site." The policy further documented at #18 of the policy: "Secure catheter utilizing a leg band."

The facility administration was informed of the findings during a briefing on 11/3/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.

*Stage 2 Pressure Injury: Partial-thickness skin

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F 315	Continued From page 19	F 315		

loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

2. Resident #3 was initially admitted to the facility on 12/10/15 with a readmission on 5/2/16. Diagnoses for Resident #3 included but are not limited to Debility, Neurogenic Bladder (abnormal bladder function caused by a nerve problem) and Metabolic Encephalopathy (describes temporary or permanent damage to the brain that happens when the body's metabolic processes are seriously impaired. Most cases occur when the liver cannot act normally to remove toxins from the bloodstream).
Resident #3's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 5/11/16 coded Resident #3 with a BIMS (Brief Interview for Mental Status) Score of 12 of 15 indicating moderate impaired cognition
In addition, the Significant Change Minimum Data Set coded Resident #3 requiring extensive assistance with two staff person assistance for transfers. Resident #3 was coded as requiring

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F 315	Continued From page 20 total dependence with one person assistance for dressing and personal hygiene. Resident #3's 7/7/16 Physician Order documented: "Provide Catheter Care as needed Catheter Care PRN (as needed)." In addition, a 7/7/16 Physician Order documented: "Provide Catheter Care every evening shift for Prevention." Resident #3's current Care Plan with a revision date of 8/16/16, documented a Focus Area of "Alteration in elimination related to complete incontinence of bowel and indwelling urinary catheter. ..." On 11/2/16 at approximately 5:20 p.m., Resident #3's foley catheter was observed lying on Resident #3's thigh with an elastic strap approximately 3/4 inches wide placed over the foley catheter tubing. No anchor device or attachment was noted on the elastic strap. LPN #6 unbuttoned the leg strap and an indentation of approximately 1/4 inch was observed on Resident #3's leg after the elastic band was removed. A new elastic leg strap was requested so that the surveyor could see if it had an anchor device on the elastic strap. A new leg strap was produced on 11/3/16 at approximately 3:00 p.m. The Director of Nursing (DON) stated after she opened the leg strap, "This is used to secure a urine leg bag." The DON stated that Resident #3 had an anchor in place currently. The facility administration was informed of the findings during a briefing on 11/3/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 315		
F 460 SS=C	BEDROOMS ASSURE FULL VISUAL PRIVACY CFR(s): 483.70(d)(1)(iv)-(v) Bedrooms must be designed or equipped to	F 460		11/25/16

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F 460	Continued From page 21 assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on general observations of the facility, the ceiling suspended curtains around the bed at the door in semi private rooms did not allow for full visual privacy on 2 of 2 facility units. The findings include: General Observations of the facility were conducted on 11/2/16 at 3:00 p.m. accompanied by the West Unit Manager Licensed Practical Nurse (LPN) #3. The Housekeeping Manager joined the tour at 3:20 p.m. Sixteen semi-private rooms on the West Unit had floor to ceiling curtains that did not go completely around the resident's bed at the door and left large open gaps, which had the potential to deny the resident total visual privacy. Twenty Five semi-private rooms on the East Unit had floor to ceiling curtains that did not go completely around the resident's bed at the door and left large open gaps, which had the potential to deny the resident total visual privacy. The Housekeeping Manager stated she was not aware the curtains did not go completely around the resident's bed at the door. On 11/3/16 at 11:30 a.m., the Administrator and	F 460	F- 460 1 New privacy curtains were hung in all rooms 2 All residents in semi pvt rooms are at risk 3 Administrator educated housekeeping director of the residents rights to privacy and the need to have proper length cubicle curtains available for semi pvt rooms 4 Administrator or designee will audit rooms randomly to ensure cubicle curtains provide privacy for residents. 5 Completion date 11-25-16	

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F 460	Continued From page 22 Corporate Nurse were shown the aforementioned problem with the resident's privacy curtains for the bed at the door. On 11/3/16 at 4:00 p.m., a debriefing was conducted with the facility Administrator, DON and corporate nurse. The Administrator stated he called a sister facility and was having replacement curtains delivered until the new ones were ordered and arrived.	F 460		